U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Behavioral Health, Disability, and Aging Policy

Advance Care Planning Among Medicare Fee-For-Service Beneficiaries and Practitioners:

Final Report

September 2020

Office of the Assistant Secretary for Planning and Evaluation

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NOTE: BHDAP was previously known as the Office of Disability, Aging, and Long-Term Care Policy (DALTCP). Only our office name has changed, not our mission, portfolio, or policy focus.

This report was prepared under contract #HHSP233201600021I between HHS's ASPE/BHDAP and RTI International. For additional information about this subject, you can visit the BHDAP home page at https://aspe.hhs.gov/bhdap or contact the ASPE Project Officers, at HHS/ASPE/BHDAP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C., 20201; William.Haltermann@hhs.gov, Iara.Oliveira@hhs.gov.

ADVANCE CARE PLANNING AMONG MEDICARE FEE-FOR-SERVICE BENEFICIARIES AND PRACTITIONERS: Final Report

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ACRONYMS

The following acronyms are mentioned in this report and/or appendix.

ACP	Advance Care Planning
AD	Advance Directive
AHRF	Area Health Resources File
BCBS	Blue Cross Blue Shield
BETOS	Berrenson-Eggers Type Of Services
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
CY	Calendar Year
E&M	Evaluation and Management
ECHO	Extension for Community Healthcare Outcomes
EHR	Electronic Health Record
FFS	Fee-For-Service
HCPCS	Healthcare Common Procedure Coding System
ICD-9	International Classification of Diseases, 9th revision
ICD-10	International Classification of Diseases, 10th revision
IPPE	Initial Preventive Physical Examination
LDS	Limited Data Set
MAC	Medicare Administrative Contractors
NCD	National Coverage Determination
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
RUC	Relative value scale Update Committee
SME	Subject Matter Expert
USPSTF	U.S. Preventive Services Task Force
VA	U.S. Department of Veterans Affairs

EXECUTIVE SUMMARY

Background

People who have a serious illness or are nearing the end of life may be unable to make decisions regarding their medical treatment and care. In these circumstances, an individual's preferences regarding medical treatment and care are often not met. Advance care planning (ACP) is a process that may better align treatment and care with personal preferences, values, and goals.

In the context of Medicare payment, the Centers for Medicare & Medicaid Services (CMS) describes ACP as a voluntary "face-to-face service between a Medicare physician (or other qualified health care professional) and a patient to discuss the patient's health care wishes if they become unable to make decisions about their care" (CMS, 2019c). As part of this discussion, the practitioner may talk about advance directives (ADs) with or without completing relevant legal forms. An AD is a document that appoints an agent and/or records the person's wishes about their medical treatment based on personal values and preferences, to be used at a future time if the individual is unable to speak for themselves. Although ACP services can help patients and practitioners better align patients' care with their values and goals, many older adults in the United States have not participated in ACP (Yadav et al., 2017; Institute of Medicine, 2014).

In 2016, CMS adopted two billing codes (Current Procedural Terminology [CPT] codes 99497 and 99498) for paying practitioners for engaging in ACP with Medicare fee-for-service (FFS) beneficiaries. In 2017, CMS started to pay certain clinicians for providing care planning and cognitive assessment services to Medicare FFS beneficiaries, first using Healthcare Common Procedure Coding System code G0505 and then CPT code 99483. The Office of the Assistant Secretary for Planning and Evaluation engaged RTI International to study the use of these billing codes among Medicare FFS beneficiaries and practitioners.

Methods

This project used quantitative and qualitative methods to examine the use of the ACP codes (billing codes 99497, 99498, and 99483/G0505) in Medicare FFS. To conduct our quantitative data analysis, we used the 5% sample of Medicare's Limited Data Set (LDS) files. The LDS files used include beneficiary enrollment and Part B service claim data from 2015 through the third quarter of 2018 for a random sample of 5% of Medicare FFS beneficiaries. We compared the characteristics of Medicare FFS beneficiaries and practitioners with billed ACP claims to those without.

Our qualitative analysis included a literature review and interviews with subject matter experts (SMEs). For our literature review, we identified prior studies examining the use of the ACP codes. We also reviewed studies that identified barriers that may inhibit and interventions that may encourage the use of the ACP codes and ACP in general. For our SME interviews, we

conducted semi-structured, key informant interviews with nine SMEs and CMS, who are knowledgeable about ACP and the ACP codes 99497, 99498, and 99483/G0505.

Results

Results from the Quantitative Data Analysis

Code Use. While only 2.81% of Medicare FFS beneficiaries had a billed 99497 in 2017, that percentage increased by almost 70%, from 1.67% in 2016. In 2017, only 0.07% of Medicare FFS beneficiaries had a billed 99498 (additional 30-minute increments of ACP after a billed 99497); 0.06% of beneficiaries had a billed 99483/G0505 (assessment and care planning for individuals with cognitive impairment). From 2016 through 2018 Quarter 3, of those beneficiaries with at least one billed ACP claim, the median beneficiary only had one billed ACP code. Of those with at least one claim billed for care planning for individuals with cognitive impairment during this almost three-year period, the beneficiary at the 75th percentile had one claim billed for assessment and care planning.

Practitioners. Internists and family medicine physicians were the highest proportion of practitioners with a billed 99497. However, nurse practitioners were most likely to provide ACP that lasts beyond 30 minutes (with a billed 99498). Neurologists and internists were the highest proportion of practitioners who billed for care planning for individuals with cognitive impairment.

Beneficiaries. Compared with beneficiaries without a billed ACP claim, those with a billed ACP claim were older, more likely to die within the calendar year (CY), and more likely to live in a county with higher socioeconomic status. In 2017, 48% of those with billed ACP lasting beyond 30 minutes died that year. Although beneficiaries with a billed claim for care planning for individuals with cognitive impairment were older than those without a billed claim, a similar percentage died within the CY.

Claims. In 2017, 63% of billed ACP services were conducted in an office and 13% in an inpatient hospital. In contrast, only 15% of billed ACP services lasting beyond 30 minutes were conducted in an office and 48% in an inpatient hospital. 89% of ACP services were billed in conjunction with another service, such as an office or outpatient visit for the evaluation and management of an established patient, and 46% were with an annual wellness visit. The vast majority (75%) of billed services for care planning for individuals with cognitive impairment were conducted in an office and only 36% were in conjunction with another service.

Results from the Qualitative Analysis

Results from our literature review and SME interviews were consistent with the patterns found in our data analysis. The low use of the ACP codes may be reflective of certain barriers, such as patient cost-sharing outside the annual wellness visit, practitioners' lack of awareness about the availability of the codes, and exclusion of certain clinical staff from independently billing these ACP codes. However, experts identified multiple interventions, including education

and training, health system redesign, and ACP process changes, that may facilitate the use of these ACP codes and ACP in general. Payers other than Medicare also have adopted these ACP codes for payment.

Discussion and Conclusion

We found low but increasing use of the ACP codes. Our interviews and literature review revealed significant barriers to using the ACP codes for both practitioners and patients. Practitioners may not be aware of the ACP codes, may still lack the time to provide ACP services, or may not be comfortable providing ACP. Patients may lack a surrogate decision-maker or be uncomfortable talking about ACP. However, payers and providers have implemented a wide variety of interventions, including education and training for both practitioners and patients, to begin to address these barriers. More education and training may help further facilitate the use of these ACP codes.